rationale for target cancer therapies based on inhibitors of DDR

Symposium: New approaches in rectal cancer

SP-0197
Consequences of bowel cancer screening programmes
M. Van Leerdam[1]
[1]*Netherlands Cancer Institute Antoni van Leeuwenhoek Hospital, Amsterdam, The Netherlands*

Colorectal cancer (CRC) is the third most common type of cancer among men and the second among women in the European region. CRC is the second most common cause of cancer related death in Europe. Several trials have shown a mortality reduction of screening by either faecal occult blood test or flexible sigmoidoscopy. Next to mortality reduction, there also is a reduction of the CRC incidence by CRC screening. Furthermore, different CRC screening modalities have been proven to be cost-effective and maybe even cost-saving. Most countries of the European Union do have a type of CRC screening, but still many countries do have opportunistic programs without an explicit policy, defined target population and without a dedicated organisation responsible for the roll out of the program. Preferable, CRC screening should be a population based program, using an up to date IT system/ data warehouse and with close monitoring and evaluation of the whole program and the outcome measures. Quality assurance is of utmost importance and can only be established in an organised program. Part of the results of the Netherlands CRC screening program will be presented as example.

SP-0198
The way forward in organ preservation strategies for rectal cancer
S. Bach[1]
[1]*Queen Elizabeth Hospital, Department of Surgery, Birmingham, United Kingdom*

Abstract not received

SP-0199
How to delineate the CTV for rectal cancer? An international consensus
V. Valentini[1]
[1]*Università Cattolica del Sacro Cuore -Policlinico A. Gemelli, Gemelli ART, Rome, Italy*

Purpose: The delineation of clinical target volume is a critical step in radiation therapy procedure. Several contouring guidelines suggest different subvolumes and anatomical limits in rectal cancer, supporting a variability in delineation that largely depends on inter-operator discordance in delineation. An international agreement among expert radiation oncologists might significantly reduce this variability, converging on a consensus rectal cancer contouring guideline through Falcon, the educational web-based multifunctional platform for delineation endorsed by ESTRO.

Material and Method: Seven skilled radiation oncologists, delegated from ESTRO, ASTRO, TROG and EORTC, defined the steps to produce consensus rectal cancer guidelines on elective nodal levels delineation. Six rectal cancer cases with different clinical stage were selected and the related CT scans were shared and uploaded on Falcon platform. The experts firstly delineated online the selected CT scan slices following each his personal guidelines. The first delineation outcome was then discussed in a face-to-face meeting with the contribution of surgeons and radiologist and a table of boundaries was compiled. All the experts had then to delineate online the same CT scan slices, considering the new table of boundaries. In a peer review meeting the final outcome was obtained and the publication plan defined.

Results: Falcon allowed a comparison of the experts' delineations, identifying critical nodal boundaries as areas of disagreement. The ontology of structure sets was defined and a new table of boundaries was generated. The major modifications to the previously published guidelines were about lateral lymph nodes (LLN) and ischiorectal fossa (IRF). One of the discussed issues was the level of the cranial and anterior border of LLN according to clinical rectal cancer stage. The delineation of the entire IRF was recommended only when there was an infiltration of the external anal sphincter or the IRF and new limits were defined (Table).

Subsite	Limits	Definition	Recommendation
Lateral lymph nodes	Anterior	When the external iliac vessels leave the pelvis, the anterior border should be limited to a virtual line at the level of the anterior wall of the ureters.	In case of: - positive nodes in the posterior lateral lymph nodes (internal iliac); - cT4; - numerous mesorectal nodes; the anterior limit is the anterior surface of obturator artery.
	Cranial	Bifurcation of common iliac artery into internal and external iliac arteries	In case of: - cT3N0; - MRF-; the cranial limit may be lowered at the level of the bifurcation of the IMA in SA and SRA (corresponding to the cranial limit of the mesorectum).
Ischiorectal fossa	Cranial	Where the inferior pudendal artery leaves the pelvis	Include both when there is an infiltration of the external anal sphincter or the ischio-rectal fossa
	Caudal	1 cm below the inferior rectal artery (which travel horizontally in the IRF)	

Conclusion: The definition of consensus guidelines for rectal cancer delineation endorsed by skilled radiation oncologists may support in reducing contouring variability. The structure sets of the six cases used will be available online as consultation atlases on the Falcon platform for individual test and a paper describing the agreed guidelines will be soon published.

Symposium: Changing paradigm in the management of kidney cancer

SP-0200
Partial nefrectomy: indication and results
P. Gontero[1]
[1]*University of Studies of Torino Molinette Hospital, Department of Surgical Sciences, Torino, Italy*

Historically, the standard treatment modality used for the vast majority of small renal masses (< 4 cm) was radical nephrectomy (RN). Partial nephrectomy (PN) was conceived to preserve renal parenchyma and function. It was pioneered in patients who would require renal replacement after RN (imperative indications). Based on the "belief" that PN is "better" than RN, utilization of PN has increased worldwide in the last few years. This has been supported by extensive literature of retrospective studies demonstrating renal functional outcomes and "overall survival" benefits of PN over RN. For T1 renal cancer (up to 7 cm lesion according to current TNM), > 95% 5 years disease specific survival rates have been reported. The probability of a positive surgical margin (PSM) on the resection bed has been shown to be below 5%. The impact of a PSM on disease recurrence remains controversial with some series suggesting no additional risk compared to a negative margin. A tumour resection technique conducted at the edge of the tumour (enucleation) has been advocated as a mean to preserve more renal parenchyma and oncologically "non-inferior" to the standard "enucleoresection" technique where a margin of up to 1 cm of healthy parenchyma is left on the resected mass. Besides, a significant reduction in the risk of developing chronic kidney disease (CKD) has been reported with PN as compared